Madison Regional Health System

Additional Dose COVID Vaccination Clinic Form (Please Print Clearly)

First Name _____ Last Name _____

Date of Birth _____ Sex _____ Age _____ Primary Provider name _____

Address _____City_____State_____Zip Code_____

Race _____ Ethnicity _____ Phone # _____ Employer _____

For Minors Only:

Emergency Contact Name_____ Emergency Contact Phone #_____

Guardian Signature_____

Questions?	Yes	No	Don't Know	N/A
1. Are you feeling sick today?				
2. Have you ever received a dose of COVID-19 vaccine? If so, which vaccine product? Pfizer / Moderna / Janssen				
3. **a**. **For moderately to severely immunocompromised:** Has it been at least 28 days since completing the initial two dose mRNA COVID-19 vaccine series?				
b. **For 65 years and older, 18+ who have underlying medical conditions, or 18+ who work or live in high risk settings:** Has it been at least 6 months since completing the initial Moderna or Pfizer two dose series? **OR** Has it been at least 2 months since receiving J&J first dose?				
4. Have you ever had a severe allergic reaction to something? Required treatment with Epinephrine or had to go to the hospital?				
a. *Was the allergic reaction after receiving a COVID-19 vaccine?				
b. *Was the severe allergic reaction after receiving another vaccine or another injectable medication?				
5. Do you have a bleeding disorder or are you taking a blood thinner?				
6. Have you ever tested positive for COVID -19 and received passive antibody therapy as treatment for COVID-19? (Monoclonal or Convalescent plasma infusions)				

For office use only below

Additional dose injection of series: Booster_____ 3rd Dose_____ Date_____

Consent _____ *V-Safe* _____ *EUA given* _____ Manufacturer Pfizer/Moderna

Lot # _____ Vaccine expiration date _____ Injection Site _____

Administered by _____

Documentation: SDIIS _____ Order entered _____ Administered on eMAR _____